STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Royal Oak	605 East Church Street Kewanee, IL 61443

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident was free from misappropriation of property for 1 of 3 residents (R1) reviewed for abuse in the sample of 5.The findings include:R1s admission record shows she was admitted on [DATE] with multiple diagnoses including bipolar disorders, borderline personality disorder and major depressive disorder.R1s resident assessment and care screening of 2/7/26 documents her to cognitively intact.R2s admission record shows he was admitted to the facility on [DATE] with multiple diagnoses including Autistic disorder, adjustment disorder and anxiety. His 3/27/26 quarterly resident assessment and care screening documents him to be cognitively intact.The facility financial abuse final report of 4/10/26 documents R1 reported her wallet stolen, and the last place where she saw it was on her bed. She stated the only person in her room was R2.On 4/24/26 at 1:22pm- R1 stated she had cashed a check a couple days before for $900, the same day she went to Walmart with another resident. She spent $500 at Walmart and had $450 left in the wallet. Then on Friday morning she noticed her wallet was missing. She told the nurse and aides, and they all started looking for the wallet. They found it in R2s room sitting on top of the dresser. R1 said (R2) swears up and down, he did not do it, but he knew she had the money. R1 said she is now out $450. She said once they found the wallet and notified the police, R1 said she would drop the charges against R2 if she could get her money back. She said now there is a lock on her nightstand, so this never happens again.On 4/24/26 at 1:30 PM, a key entry lock was observed on the top drawer of her nightstand.On 4/28/26 at 10:23 AM, V6 social service said she remembers cashing a check for R1, in the amount of $900. The check was from the company, and she advised R1 to hide it or have the business office keep it safe. She said R1 decided to keep it on her person.On 4/24/26 at 12:25 PM, V10 Certified Nursing Aide (CNA) said R1 had reported to her that the wallet was missing and had about $500 inside. V10 said she reported it to the nurse, and with V9 CNA, they searched her room and R2s room. The wallet was found on top of R2s dresser, and the money was missing. On 4/24/26 at 1:39pm, R2 said he did not know how the wallet ended up in his room. He said before that, he had been out with R1 to Walmart, Burger King and Scooters, then returned to the facility. He did not know when the wallet appeared in his room. The police were here and charged me with theft because it was found in my room.R1 nursing progress note of 4/2/26 at 1:11 PM documents V6 cased a check for R1 and counted the money to the resident, and requested she keep the money safe and secure.R1s progress note of 4/4/26 at 10:49 AM, notes V2 Administrator in Training and V7 Assistant Administrator were called due to R1 being upset over her property being stolen. R1 stated her wallet was stolen and it was found in (R2) room. R1 reported she had money in her wallet, when it was returned to her the money was gone. Resident accepted the offer to speak to the police department.On 4/24/26 at 11:30 AM, V7 said she completed the investigation with V2. She said R1 reported to her R2 had stolen her wallet and money. R1 reported she had just been shopping and returned to the facility with $400 and the wallet was found in R2s room with the money missing. V7 said she interviewed the staff and R2 regarding the wallet and money. She said the police were notified and spoke with R2, and he denied taking the money, but R2 was issued a notice to appear in court for May 1, 2026. She said there were no other complaints, and the theft was substantiated.The (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's 9/2024 policy for abuse prevention and reporting documents this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to supervise a resident at high risk for elopement while on a 1:1 monitoring. This failure resulted in R4 leaving the facility unauthorized, and fracturing her foot while climbing/jumping over a fence. This failure applies to 1 of 3 residents reviewed for safety and supervision. The immediate Jeopardy began on 3/14/26 when V13 Certified Nursing Assistant (CNA) allowed R4 to shut her door and remain out of her line of vision while on a 1:1 monitoring status, allowing R4 to elope out of her window. V2 Administrator in Training was notified of the Immediate Jeopardy on 4/30/26 at 9:00 AM. The surveyor confirmed by observation, interview and record review that the immediate jeopardy was removed, and the deficient practice corrected on 3/16/26, prior to the start of the survey and was therefore Past Noncompliance. Based on observation, interview and record review, the facility failed to ensure a resident with a history of substance abuse was safe from an opioid medication not prescribed to him (R3), this failure resulted in R3 overdosing, and being sent to the emergency room for stabilization, and subsequently hospitalized for psychiatric treatment.The findings include:The findings include: 1. R4s admission record documents she was admitted on [DATE] with diagnoses of schizophrenia, unspecified psychosis, and major depressive disorder. The 3/5/26 elopement/unauthorized leave risk review notes R4 had a history of wandering/elopement and verbalized a strong desire to leave and had a diagnosis of severe mental illness. The elopement risk decision of the same document shows R4 to be at risk to elope and should be placed on the elopement risk protocol. A care plan for elopement is indicated. R4s care plan initiated on 3/5/26 states the resident is an elopement risk/wanderer related to schizophrenia and psychosis. The 3/15/26 resident assessment and care screening documents R4 to have severe cognitive impairment. R4s psychiatry note and initial evaluation of 3/11/26 documents her to have schizophrenia, cocaine abuse, opioid abuse, nicotine dependence, and insomnia. Staff report ongoing behavioral concerns including a history of running away and recent exit-seeking behavior, with the patient observed scanning perimeter fencing for possible ways to leave the grounds. R4s nursing progress notes of 3/9/26 documents she was trying to use the keypad to exit the building, pacing and looking at the exit door. On 3/10/26 she was pushing on exit doors and setting off alarms. She had hovered around exit doors and had kicked and pushed open the exit door and tried to climb through windows. On 3/11/26 she was hovering at the ambulance exit and pacing, looking out and touching the keypad. On 3/12/26 she exited the facility doors and was returned to the facility by social services. The facility incident report of 3/14/26 documents R4 sustained an unwitnessed fall on facility grounds during an unauthorized exit. Upon investigation, review of clinical records, assessment, hospital documentation, statements of staff on duty, and statement from R4, it was found that R4 exited the building and climbed over fence, landing on the ground. Since her return from the emergency department, she remains on a 1:1 supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospital records for R4 show on 3/14/26 she arrived at 7:05 AM and had complaints of foot pain secondary to jumping over the fence of the nursing home trying to escape. Xray's were completed and showed a displaced fracture of the metatarsal bone of the left foot. On 4/28/26 at 9:46 AM, V11, Licensed Practical Nurse LPN said she has been working on the behavioral unit for about 4 years. When she arrived on 3/14/26 the night shift aide assigned the 1:1 for R4 was giving report to the oncoming day shift aide taking over the monitoring. The day shift aide (V14) reported to her R4 was not in her room. V11 said she initiated a headcount and staff searched the facility. R4 was found out front of the building by a tree, holding herself up because she had injured her foot. R4 had climbed out her window and jumped the fence and went through the main dining room and exited out the activity door. She did not make it very far, but if she had not injured herself, she would have been gone. V11 said she was not sure how long R4 had been outside. She said R4 had been on 1:1 when the elopement occurred. When she asked V14, she was told the night shift aide reported that R4 was in the bathroom. V11 said R4 is alert and oriented but does have delusions and hallucinations and not always oriented to the time. She has been exit seeking since she arrived. On 4/28/26 at 10:00 AM, V11 walked through the path of R4's elopement with this surveyor. R4's former room was observed to have a shared bathroom, and a fence outside of the room. The fence appears to be approximately 6 feet high. On the other side of the fence is the smoking patio leading into the main dining room. Across the dining room is the activity room with an alarmed door. Just outside of the activity door is a large tree. V11 stated that was where R4 was located. On 4/28/26 at 10:30 AM, R4 was observed sitting in the doorway of her room with a staff member next to her. She was alert and appeared guarded with answering questions. She said she would like to go somewhere else. On 4/28/26 at 11:44 AM, V14 said on 3/14/26 at 6:00 AM, she was assigned the 1:1 with R4 due to her elopement risk. When she arrived to relieve V13 CNA, she asked V13 why the door was shut to R4's room. V14 said the door was all the way shut so she opened it and asked V13 where R4 was located. V13 told her she was in the bathroom. V13 said she put her stuff away for the shift and came back and opened the door and R4 was not in the room. She said the window was open and R4 was gone. V14 immediately reported R4 missing to the nurse. She said the staff started doing room checks and then one of the staff members found her outside. V14 said when a resident is on a 1:1 the door should never be shut, and the resident should not be out of sight. V14 said R4 was missing for about 15 minutes. She had been on 1:1 due to her intentions to leave the facility. On 4/29/26 at 11:45 AM, V13 said while working night shift she was assigned the 1:1 with R4. V13 said during the night of 3/13/26 into the 3/14/26 morning hours, R4 had been up visiting, eating and sleeping. V13 said at 5:45 AM, which is her last 15-minute check on her monitoring sheet, R4 was in her room on the floor. Then shortly after that, R4 said she wanted to use the bathroom. She left the bedroom door open so she could see the bathroom door, and she saw R4 enter the bathroom. V13 said when V14 arrived she tried to close the door, and told V14 she could not do that. She said report was given to R14 and then she left. V13 said when a resident is on 1:1 you have to keep an eye on them at all times. If you have to use the bathroom, someone has to sit and watch that resident for you. She was not sure why R4 was on a 1:1 but was told she was an elopement risk and had behaviors. On 4/28/26 at 11:09 AM, V2 said R4 was a high risk for elopement and had been a resident on the alarmed behavior unit since her admission. V15 Care plan coordinator said R4 had behaviors including (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pacing the hallway, kicking at the door and pushing on the doors and walking away really quick. She was placed on 1:1 on 3/12/26 when she exited the building. V15 said R4 took off with social services following her to bring her back. When she returned, R4 had a blank stare, and we tried to encourage her to express her thoughts and respond to us. V2 stated during 1:1 the resident should be in eye contact with the aide at all times. She said the bedroom door cannot be shut. The facility's 1/2026 policy for code pink-missing resident/elopement documents the facility strives to promote resident safety and protect the rights and dignity of the residents. Elopement is the ability of a cognately impaired resident, who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed and who may enter into harms way. The Inservice sign in sheet of 3/14/26 details a 1:1 status. When someone is placed on 1:1 and you are assigned to do said task, you are to stay with that resident at all times. You may sit in the hall if they are in their room or in the bed, but the door must be opened and resident in sight. If residents are persistent in shutting the door, you should position yourself in the doorway and explain that you have to be able to see them. Prior to the survey date of 4/30/26, the facility had taken the following action to correct the noncompliance: 1. On 3/14/26 all residents were re-evaluated for risk of elopement and community survival skills. Care plans were audited to ensure it matched the resident risk of elopement. Elopement binder was audited by social services. 2. On 3/14/26, all residents will continue to be evaluated for elopement risk at admission, readmission, quarterly, annually, significant change and incidentally if risk behaviors are identified. 3. On 3/16/26, the elopement policy was reviewed by IDT to ensure processes address enhanced supervision and person-centered interventions. QA to review policy and procedure as part of Quality Assurance Process for each quarterly meeting x4. 4. On 3/14/26 and 3/15/26 elopement drills were conducted for all shifts. Agency staff are educated on elopement policy prior to accepting agency shifts at the facility. Staff were educated on the elopement policy on 3/14/26, 3/15/26 and 3/16/26. 5. QA audits will be conducted on 1:1 monitoring 3 times a week for 4 weeks. Staff member who failed to fulfill 1:1 monitoring duties appropriately for resident was verbally suspended on 3/14/26. 6. All staff were in-serviced on door alarms on 3/14/26, 3/15/26 and 3/16/26. QA audit on alarm response will be conducted 3 times weekly for 4 weeks. 2. The facility's final incident report sent to the IDPH (Illinois Department of Public Health) showed R3 was found lying on his bed and not responding to staff on 4/4/26 at 4:30 PM. The nurse assessed R3, performed a sternal rub, and administered naloxone (medication to reverse opioid overdose). The report showed R3 was transferred to the local emergency room for further treatment. The report showed it was determined that R3 had obtained and self-administered an opioid analgesic not prescribed to him. R3 was medically cleared and subsequently hospitalized for psychiatric treatment. R3's face sheet printed on 4/24/26 showed diagnoses including but not limited to schizophrenia, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	chronic obstructive pulmonary disease, anxiety disorder, bipolar disorder and major depression. R3's facility assessment dated [DATE] showed cognitively intact and no memory problems. R3's care plan showed a focus area related to behavior problems. History of going out with grandparents and having them buy vape pens and alcohol while in their care. He has come back intoxicated or under the influence of unknown substances. Interventions included power of attorney wants family not to take resident out on outings and to have supervised visits in facility in common areas (initiated 8/22/24). On 4/24/26 at 11:25 AM, R3 was self-ambulating down the hall of the locked behavior unit he resides on. R3 was alert, calm and coherent. R3 stated he went out to the hospital a couple of weeks ago because he was breathing strange. R3 said he wasn't sure what happened, he just woke up in the hospital. R3 said they sent him to a mental hospital after that. R3 said when he returned to the facility a nurse (V4) told him he tested positive for oxy (oxycodone=opioid medication used to treat pain) at the hospital. R3 said I don't know how it happened, but my roommate (R5) had medications in the room. We don't live together anymore; they changed our rooms after I got back. R3 said he found his roommate's medication in the dresser drawer but denied taking the medication. R3 would not elaborate on what form or type of medication he found in the dresser. On 4/24/26 at 11:40 AM, V3 (Licensed Practical Nurse) stated she heard in a morning report that R3 had been found unresponsive in his room. He had overdosed on something. He went out to the hospital and since his return, we are supposed to keep him away from (R5). I think the incident had something to do with (R5), but I am not sure. All I know is we are supposed to keep them apart. On 4/24/26 at 12:55 PM, V4 (Licensed Practical Nurse) said R3 has good cognition, can recall past events and has no memory problems. V4 said on the day of the incident, a CNA (certified Nurse Aide) told her R3 was acting weird so she went in the room with another nurse (V16) to check on him. R3 was lying on the bed and not responding. R3 was showing obvious signs of a drug overdose. He was breathing slowly, in a super deep sleep, and not responding to chest rubs. 911 was called immediately and they eventually took him to the emergency room. R3 was breathing when he went out. V4 said I've worked with drug type patients before and unfortunately know very well what that looks like. It was very obvious R3 had a drug overdose. On 4/29/26 at 9:20 AM, V16 (Licensed Practical Nurse) stated she responded with V4 the day of R3's incident. V16 said it was weird all round. R3 lives on a locked unit but is allowed to have unsupervised visits with his grandparents. R3's grandparents did visit that morning and they went outside together. Another resident was out there too. The grandparents are known to bring contraband into the building in the past. That afternoon I went down to R3's room and he was high and really out of it. The administrator was on the unit too talking with V4. I went back to check on R3 and he was unresponsive. I was shaking him and doing sternal rubs. He was breathing strange and V4 gave him Narcan (naloxone) twice. He did get slightly better and the EMTs came right away. They transferred him out. R3 was breathing but still out of it. I heard they found a white powdery substance in his room. I got a call from the emergency room nurse later and they updated me that he tested positive for oxycodone. On 4/29/26 at 8:50 AM, V17 (CNA) stated she saw R3 the day of the incident walking down the hallway wearing sunglasses and stumbling into his room. V17 said she alerted the nurse. V4 and V16 (nurses) went to check on him. They both went in right away and started working on him The nurses both were doing chest rubs and gave him Narcan. 911 was called and they took him out. V17 said she (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	searched the room once the EMTs left and found a white, powdery substance in a dresser drawer. V17 found empty bags with some white powdery, substance in it. V17 said she assumed it was cocaine or something like that and that R3 had snorted it. V17 said she overheard a nurse on the phone later saying something about an oxycodone prescription since 3/27. R3's April 2026 physician order report was reviewed. There was no prescription for oxycodone. R3's urine drug screen performed at the local emergency room and dated 4/4/26 showed a positive result for oxycodone. R5's April 2026 physician order report was reviewed and showed an order start dated 3/27/26 for oxycodone 5 milligrams to be given as needed every 6 hours for pain related to fracture of right tibia. R5's face sheet showed an admission date of 3/26/26 and admitting diagnosis of right tabia leg fracture. R3 and R5's electronic census tab showed they did room together on 4/4/26 (day of incident). On 4/24/26 at 11:45 AM, V5 (Director of Nurses) stated R3 did have an overdose on oxycodone, just like he said. That was the diagnosis given at the emergency room. The day of the incident the administrator saw that he was not acting like himself. She told the nurse (V4) to keep an eye on him. Later, the CNA told the nurse he was unresponsive. His breathing was off and 911 was called. Yes, oxycodone was found in his system. I don't know 100% where he got it. He did have a grandparents visit that day but those are to be supervised. That has been care planned since August of 2024. V5 reviewed R3's electronic record and confirmed there was not an order for oxycodone. V5 reviewed R5's electronic record and confirmed there was an order for oxycodone at the time of the incident. V5 said we have concerns with both of them being together. Both have history of substance abuse. It is plausible R3 took R5's medication. I can't confirm where he got it. Maybe one of his grandparent's brought it in. Maybe R5 still had it with him upon admission. I investigated the situation and don't know where it came from. Either way something failed. There are multiple processes that could have been better. For example, better supervision in a couple of ways for one thing. R3's emergency room record dated 4/4/26 showed he was medically stabilized and evaluated by a mental health counselor, who recommended hospitalization for ongoing suicidal ideation. The record showed R3 was transferred the same day to the mental health facility. R3's progress notes showed he did not return to the facility until 4/11/26 (7 days later). R5's progress notes dated 4/4/26 (day of incident) showed R5 was found snorting something in his room. A crushed-up substance was found on the resident's dresser and a pen that had been taken apart. R5's care plan showed a newer focus area start dated 4/6/26. Behavior problem with pocketing medications and saving medications to take later. Hiding vapes and medications from home. The facility's Medication Administration Policy last review dated 1/2026 stated: Medications must be administered in accordance with a physician's order, e.g. the right resident, right medication, right dosage, right route and right time.Medication supplied to one resident may not be administered to another resident. The facility's Medication Storage policy states: Facility should store Schedule II Controlled Substances and other medications deemed by facility to be at risk for abuse or diversion in a separate compartment.2. Facility should ensure that all medications and biologicals, including treatment items, (continued on next page)

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